MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 CD 03758

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:
County Cecil
City or town Rural Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Logan Nursing Home
How long in hospital or institution? 18 hrs - 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED Lancaster
(For newborn infants give residence of mother)
State Penna County Chester
City or town Peach Bottom
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Joseph Richard Barrett

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 15, 1948

8. AGE:

Years	Months	Days	If less than one day
—	—	—	13 hrs. 30 min.

9. Birthplace Rising Sun Rural Cecil Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Maurice Henry Barrett
13. Birthplace West Nottingham, Md.

MOTHER 14. Maiden name Anna E. Hupp
15. Birthplace West Phila. Pa.

16. Informant Mrs. Maurice H. Barrett
Address Peach Bottom, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16, 1948 (month) (day) (year)
Cemetery or crematory Harmony Chapel
Location Port Deposit, Md.

18. Funeral director Lee A. Patterson & Son
Address Delta, Md.

19. April 16 1948 (Date rec'd by registrar) L. Worthington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1948 to April 16, 1948 and that I last saw him alive on April 16, 1948

Immediate cause of death	DURATION
Prematurity	
Due to Premature Labor; Child about 7 months pregnancy,	
Due to birth wt. 3 pounds.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John D. Brittingham M.D.
M. D. or other
Address Oxford, Pa. Date signed 4-16-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03759

96

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ hours.

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? about 1½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Levis C. Blackburn.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife: Sena Blackburn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 10. 1872

8. AGE: Years: 76 Months: 2 Days: 24 If less than one day: ..... hrs. ..... min.

9. Birthplace: Rowlandsville, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: James A. Blackburn

FATHER — 13. Birthplace: Rowlandsville, Md.

MOTHER — 14. Maiden name: Marian Hinze

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Levis Blackburn Jr.

Address: North East, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7. 1948 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Near Pennsville, Md.

18. Funeral director: J. E. Larson

Address: Rising Sun, Md.

19. April 5 1948 (Date rec'd by registrar) F B Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1948 at 12:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1948, to April 4 1948

and that I last saw h... alive on April 4 1948

	DURATION
Immediate cause of death: Abdominal Hemorrhage	
Due to: Ruptured aneurysm of abdominal aorta; Non-syphilitic	
Due to:	
Other conditions: Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M/D. or other

Address: 202 E Main St Date signed 4/4/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03760

490

CERTIFICATE OF DEATH

Reg. Diat. No. 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Cecil Co.
City or town Rising Sun Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil Co.
City or town Rising Sun, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth K. Burbins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Harry B. Burbins
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10-1888

8. AGE: Years	Months	Days	If less than one day
60	3	7	hrs. min.

9. Birthplace Conowingo Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Randolph Barrow
13. Birthplace Conowingo Md

MOTHER
14. Maiden name Rachel Lovestine
15. Birthplace Conowingo Md.

16. Informant Charles Burbins
Address Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20 1948 (month) (day) (year)
Cemetery or crematory Brookview
Location Rising Sun Md.

18. Funeral director J. E. Tyson.
Address Rising Sun Md.

19. Apr 19 1948 E. M. Worthington Registrar
(Date rec'd by registrar)

Permit paid 4-19-48

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948, at 3306 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carcinoma of Breast.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address Rising Sun Md. Date signed 4/17-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03761

13 b

CERTIFICATE OF DEATH

Reg. Diat. No. 95

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Cecil

City or town: Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Samuel Ray Drennen.

3. (b) Social Security Number

4. Sex: M.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Reba H Drennen.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): aug 10 1880

8. AGE: Years: 67 Months: 9 Days: 15 If less than one day: ..... hrs. ..... min.

9. Birthplace: Perryville Md.

(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Jesse Milton Drennen.

FATHER 13. Birthplace: Perryville Md.

MOTHER 14. Maiden name: Mary Rogers.

MOTHER 15. Birthplace: Perryville Md.

16. Informant: George Drennen.

Address: Kirkwood Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28, 1948 (month) (day) (year)

Cemetery or crematory: Oxford Cemetery

Location: Oxford, Pa.

18. Funeral director: Ralph M. Reed

Address: Rising Sun, Md.

19. (Date rec'd by registrar) Apr 26 1948 Registrar

Permit issued 4-26-48

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1948 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1936 to 4/25 1948

and that I last saw h... alive on 4/24 - 1948

Immediate cause of death	DURATION
Tuberculosis Pulmonary	
Due to (5/24/48 CD)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R L Hodson MD M. D. or other

Address: Rising Sun Md. Date signed 4/25-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03762

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County: Cecil

City or town: Earlville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? ~

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Earlville

(If outside city or town limits, write RURAL and give nearest town)

Street No. ~

(If rural, give LOCATION)

2.(a) If veteran, name war ~

3. (a) FULL NAME Mary Sophia DuHamell

3. (b) Social Security Number ~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Henry Dillon DuHamell

6.(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.): July 1 - 1855

8. AGE: Years	Months	Days	If less than one day
92	9	18	...hrs. ...min.

9. Birthplace: Foxboro - Mass.

(Town, county, and state)

10. Usual occupation: Home -

11. Industry or business ~

FATHER

12. Name: Obediah Sherman

13. Birthplace: Foxboro - Mass.

MOTHER

14. Maiden name: Julia Cooke

15. Birthplace: Worcester, Mass.

16. Informant: Ethel DuHamell Collen

Address: Earlville - Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: April 22 1948 (month) (day) (year)

Cemetery or crematory: Westminster Cem. (New Columbus)

Location: New Columbus Md.

18. Funeral director: Edward Kellow

Address: Millington Md.

19. Apr 21 - 1948 Mrs. Harvey A. Clayney Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1948, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15th 1948, to April 19th 1948

and that I last saw h... alive on April 18th 1948.

Immediate cause of death	DURATION
Coronary Sclerosis	~
adeptia for	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dorsey W. Lewis M. D. or other

Address: Middletown - Del. Date signed: 4/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03763

92c

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Matilda Finnberg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Vaino Finnberg
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Sept 1 - 1895

8. AGE:

Years	Months	Days	If less than one day
52	7	11	hrs. min.

9. Birthplace: Sippola Usp. L. Finland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Esa Tapola
13. Birthplace: Finland

MOTHER
14. Maiden name: no information
15. Birthplace

16. Informant: Vaino Finnberg
Address: North East, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 14 1948 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: North East Maryland
18. Funeral director: Joseph R. Grant
Address: North East, Maryland

19. April 13 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 April 1948, at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946, to 11 April 1948
and that I last saw h.e.r alive on 11 April 1948

Immediate cause of death	DURATION
Pulmonary edema	24 hrs
Due to: Chronic Rheumatic Endocarditis	20 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Klaus H Huebner M.D.
M. D. or other
Address: North East, Md Date signed: 12 April 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03764

54a CB

Reg. Dist. No. 96

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
VETERAN's ADMINISTRATION HOSPITAL

How long in hospital or institution? 21 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Harrison

City or town: Salem, Route 2, Box 96
(If outside city or town limits, write RURAL and give nearest town)

Street No.: None
(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1

3.(a) FULL NAME: FLANIGAN, Jackson L.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Iva Casey Flanigan

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): March 17, 1997

8. AGE: Years	Months	Days	If less than one day
51	0	24	...hrs. ...min.

9. Birthplace: Harrison County, West Virginia
(Town, county, and state)

10. Usual occupation: Glass Worker

11. Industry or business

FATHER 12. Name: William Flanigan

13. Birthplace: Harrison County, West Virginia

MOTHER 14. Maiden name: Tina Varner

15. Birthplace: Harrison County, West Virginia

16. Informant: Iva Casey Flanigan

Address: Salem, Route 2, West Virginia

17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 11, 1948 (month) (day) (year)

Cemetery: Mt. Olive Cemetary

Location: Route 3, Salem, West Virginia

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. April 11 1948 (Date rec'd by registrar) Irma E. Douglas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 19 48, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 48, to April 10 19 48 and that I last saw him alive on April 10 19 48

Immediate cause of death	DURATION
Respiratory failure	
Post operative	
Due to: Brain tumor	4 months plus
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Massive brain tumor, probably glioma, rt. cerebrum Date of op.

Autopsy results: Not obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. David Dunton, M.D. M. D. or other

Address: VA HOSPITAL, PERRY POINT, Md. Date signed: April 10, 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03765

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CERTIFICATE OF DEATH

Reg. Dist. No. 92

M C I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 hours.

Hospital, institution, or street address where death occurred: Union Hospital Elkton Md

How long in hospital or institution? 16 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert William Frazer.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 30 1947.

8. AGE: Years | Months: 6 | Days: 17. | If less than one day: ..... hrs. ..... min.

9. Birthplace: Wilmington Del. (Town, county, and state)

10. Usual occupation: Child Infant

11. Industry or business

FATHER — 12. Name: George B Frazer.

13. Birthplace: Elkton Md.

MOTHER — 14. Maiden name: Mabel Guhl.

15. Birthplace: Cumberland Md

16. Informant: George B. Frazer

Address: Elkton Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 20 1948 (month) (day) (year)

Cemetery or crematory: Sharpes Md

Location: Fair Hill Md

18. Funeral director: P. T. Jones

Address: Newark Del

19. April 19 19 48 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Bilateral Bronchial Pneumonia	
Due to:	
Tendency to Mongoliansism	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R Sheldon Jones M.D. Medical Examiner for Cecil County M. D. or other

Address: Rising Sun Md Date signed 4-17-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

54b

63766

Reg. Dist. No. 96

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 429 Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-II ✓

3.(a) FULL NAME

GILLIAM, William M. Gilliam

3.(b) Social Security Number

Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male M	White	Divorced

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1897

8. AGE:

Years	Months	Days	If less than one day
50	4	24	..... hrs. ..... min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Unknown Painter

11. Industry or business

FATHER

12. Name: Mrs. J.H. Gilliam

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital records

Address: VA Hospital, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-4-48 (month) (day) (year)

Cemetery or crematory: Unknown

Location: Rome, Georgia

18. Funeral director: Pennington & Son

Address: PENNINGTON & SON Havre de Grace, Md.

19. April 5 1948 (Date rec'd by registrar) Irma E. Dempsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1948 at 5:45AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1948, to April 2, 1948 and that I last saw him alive on April 2, 1948

Immediate cause of death	DURATION
Malignant tumor of the brain, frontal lobe	Unknown
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.:

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R.C. Dodson M.D. Medical Examiner for Cecil County
R.C. DODSON, Coroner, Cecil Co. M. D. or other

Address: Rising Sun, Md. Date signed: 4-2-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

922

03767

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 Years

Hospital, institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Giorgio

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Italian	Married

6.(b) Name of husband or wife: Francisco Giorgio

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March ? 1879

8. AGE: Years	Months	Days	If less than one day
69			....hrs. ....min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: Matthew De Nardo

13. Birthplace: Italy

MOTHER — 14. Maiden name: Antoinetta Pecia

15. Birthplace: Italy

16. Informant: Francisco Giorgio

Address: Port Deposit, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28, 1948 (month) (day) (year)

Cemetery or crematory: Brookview Cemetery

Location: Rising Sun, Md. Rural

18. Funeral director: W. A. Patterson & Son.

Address: Perryville, Md.

19. April 28 1948 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1948, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20 1948, to Apr. 24 1948

and that I last saw h[illegible] alive on April 24 1948

Immediate cause of death	DURATION
(a) Chr. Myocarditis	8 yrs
Due to (b) Chr. Endocarditis	8 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. J. Benson M. D.
M. D. or other

Address: Port Deposit Md. Date signed 4/27/48.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03768

107 CB

Reg. Dist. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 hours.

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 19 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Del. County: New Castle

City or town: Newark R D 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Ronald D Hanna.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 21 1948.

8. AGE: Years | Months: 1 | Days: 22. | If less than one day: hrs. min.

9. Birthplace: Wilmington Del. (Town, county, and state)

10. Usual occupation: Child.

11. Industry or business:

FATHER 12. Name: Roland Hanna Jr.

13. Birthplace: Lancaster Co Pa.

MOTHER 14. Maiden name: Gladys Roarke.

15. Birthplace: Asheville N.C.

16. Informant: Union Hospital record.

Address: Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 15-48 (month) (day) (year)

Cemetery or crematory: Glasgow Cemetery

Location: Glasgow Delaware

18. Funeral director: A W Hopkins

Address: Elkton, Md.

19. April 13 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1948, at 7.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Bronchio Pneumonia	
Due to: Bilateral	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R L Dodson MD Medical Examiner Cecil County

M. D. or other

Address: Elkton Md. Date signed: 4/12-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03769

55e

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: County Cecil; City or town Elkton (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 5 yrs; Hospital, Institution, or street address where death occurred: 136 E High St; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Maryland; County Cecil; City or town Elkton (If outside city or town limits, write RURAL and give nearest town); Street No. 136 E High (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Maurice Edgar Hudson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie Hudson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 21 1895

8. AGE: Years 52; Months; Days; If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Game Warden

11. Industry or business

FATHER 12. Name: Joshua Hudson

13. Birthplace: Maryland

MOTHER 14. Maiden name: Maggie Beckworth

15. Birthplace: Maryland

16. Informant: Mrs Elsie Hudson

Address: 136 E High St Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 6 1948 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Chesapeake City Md RD

18. Funeral director: H W Pippin

Address: Elkton Md

19. April 6 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1948, at 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1947 to April 3 1948 and that I last saw h[im] alive on April 3 1948

Immediate cause of death: Carcinoma of the neck, left, with involvement of the glands

	DURATION
Due to:	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L Ralph Andrews Jr., M.D. (M.D. or other)

Address: Elkton, Md. Date signed April 5, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Bates 03770 131a

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, Institution, or street address where death occurred: W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Cecil.

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

Street No.: W. Main St (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Malvern T. Jeffers.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Wh.	Married.

6.(b) Name of husband or wife: Josephine K. Jeffers. 6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): January 18, 1873

8. AGE: Years 75 Months 3 Days 22 If less than one day ..... hrs. ..... min.

9. Birthplace: Elkton, Md. (Town, county, and state)

10. Usual occupation: Retd Boat Builder

11. Industry or business

FATHER 12. Name: Herman Jeffers.

13. Birthplace: Elkton, Md.

MOTHER 14. Maiden name: Jennie Cantwell

15. Birthplace: Elkton, Md.

16. Informant: Mrs Josephine K. Jeffers. Address: W. Main St Elkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 12 '48 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton, Md

18. Funeral director: H. W. Lippincott

Address: Elkton, Md

19. April 12 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1948 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1930 to Apr 9 1948 and that I last saw h... alive on April 9 1948

Immediate cause of death	DURATION
Acute Cardiac dilatation	
Due to: Cardio renal vascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herbert Bates, M.D. M. D. or other

Address: Elkton Md Date signed: 4/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03771

CERTIFICATE OF DEATH

Reg. Dist. No. 92

M

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elijah Lyle

3.(b) Social Security Number 705-09-7329

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	married

6.(b) Name of husband or wife: Sarah Lyle
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): April 4 1902.

8. AGE: Years	Months	Days	If less than one day
45	11	1	hrs. min.

9. Birthplace: Farmville Va.
(Town, county, and state)
10. Usual occupation: Track Foreman.
11. Industry or business
FATHER 12. Name: Mollie Lyle.
FATHER 13. Birthplace: Farmville Va.
MOTHER 14. Maiden name: Sally Henderson
MOTHER 15. Birthplace: Farmville Va.
16. Informant: Robert Lyle.
Address: Elkton Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-4-48 (month) (day) (year)
Cemetery or crematory: Keysville Va.
Location: Keysville Va.
18. Funeral director: Edw R. Bell
Address: 909 Poplar St. Wil. Del.
19. April 5 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1948 at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Medical Examiner Cecil County
Address: Rising Sun Md. M. D. or other
Date signed: 4-1-48

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03772

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war: not a veteran

3.(a) FULL NAME: Charles J. McCauley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widdowed

6.(b) Name of husband or wife: Katie Long McCauley

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): January 28 1861

8. AGE: Years: 87 | Months: 2 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Elkton Rural Cecil Co Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: James J. McCauley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Biddle
15. Birthplace: Maryland

16. Informant: C. Otis McCauley
Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-10-48 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Cherry Hill Maryland

18. Funeral director: Joseph P. Fraser
Address: North East Md

19. April 9 1948 (Date rec'd by registrar) J. P. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1948 at 11A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930 to April 7 1948 and that I last saw h— alive on April 6 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: arterio sclerosis, General	
Due to:	
Other conditions: Gangrene of foot	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Herbert Bates M. D.
M. D. or other

Address: Elkton Md Date signed 4/9/48

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03773

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 21 days

Hospital, Institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Independent City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1818 Lorman Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: THOMAS MC COY

3.(b) Social Security Number: 216-08-8195

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 5, 1885

8. AGE: Years	Months	Days	If less than one day
63	2	10	..... hrs. ..... min.

9. Birthplace: Hyacinth, Va. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-16-48 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Thomas E. Kelson - Geo. D. Kelson

Address: 1303 Presstman Ave., Baltimore, Md.

19. April 16 1948 (Date rec'd by registrar) Irene E. Daughety (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15th 1948 at 12Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24th 1948 to April 15th 1948 and that I last saw him alive on April 15th 1948

	DURATION
Immediate cause of death: Cerebral hemorrhage	5 min.
Due to: Syphilitic heart disease	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: A. E. TROLLINGER, M.D., Chf. Prof. Services M. D. or Other

Address: VAH, Perry Point, Md. Date signed: 4-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940 mc

-03774

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours.

Hospital, institution, or street address where death occurred: Union Hospital Elkton Md.

How long in hospital or institution? 3 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1741 Montpelier St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Robert Lee Michael

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Widowed

6.(b) Name of husband or wife: Florence Michael

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 10 1879.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	8	2.		

9. Birthplace: Harford Co Md. (town, county, and state)

10. Usual occupation: Engineer R.R.

11. Industry or business:

FATHER

12. Name: James Michael

13. Birthplace: Harford Co. Md.

MOTHER

14. Maiden name: Emily Cox

15. Birthplace: Harford Co. Md.

16. Informant: Miss Gwendolyn V. Michael

Address: 1741 Montpelier St Balto 18. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 1948 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Jenkinson Md.

18. Funeral director: Henry Tanning Sons.

Address: Aberdeen Md

19. April 12 1948 (Date rec'd by registrar) F R Brazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1948 at 6:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Ledorson M.D. Medical Examiner for Cecil County

Address: Elkton Md. Date signed: 4/12-48 M. D. or other

M

I

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1578 03775

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hollingsworth Manor.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Patricia Ann Wyeun

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	S.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 25, 1948

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Elkton Cecil Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: James F. Wyeun
13. Birthplace: Blair Co. Pa.

MOTHER
14. Maiden name: Mariam Coffman
15. Birthplace: Perryville Md.

18. Informant: J. F. Wyeun
Address: 72 Hollingsworth, Elkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 27 1948 (month) (day) (year)
Cemetery or crematory: Lakewood
Location: Post Belvidere Md. Rural

18. Funeral director: Lee A. Catterson & Son
Address: Perryville, Md.

19. April 27 1948 (Date rec'd by registrar) F. R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 April 1948, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 April 1948, to 26 April 1948 and that I last saw her alive on 26 April 1948

	DURATION
Immediate cause of death: Respiratory Failure	2 Days
Due to: Intracranial Abnormality	2 Days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George J. Kreis, Jr. M. D. or other
Address: Elkton, Md. Date signed: 27 April '48

03776

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

Reg. Dist. No. 91

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH: County Cecil; City or town Chesapeake City, " "

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No. Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ella Ma Prosser

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Wh	Married.

6.(b) Name of husband or wife Wells T. Prosser.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May. 25, 1903

8. AGE: Years	Months	Days	If less than one day
44	10	13	..... hrs. ..... min.

9. Birthplace Chesapeake City Md (Town, county, and state)

10. Usual occupation at Home.

11. Industry or business

FATHER 12. Name George Cotter

FATHER 13. Birthplace Chesapeake City, Md

MOTHER 14. Maiden name Mrs Jones

MOTHER 15. Birthplace

16. Informant Wells T. Prosser.

Address Chesapeake City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9 1948 (month) (day) (year)

Cemetery or crematory Bethel Imm Ches. City.

Location Chesapeake City Md

18. Funeral director Hollopeter

Address Elkton, Md

19. April 9 1948 (Date rec'd by registrar) Ina Brookhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948 at 12 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1948 to April 7 1948

and that I last saw h.. alive on April 6 1948

Immediate cause of death Carcinoma of uterus

DURATION 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Carcinoma of body of uterus Date of op. April 8 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos J Davis MD M. D. or other

Address Chesapeake City, Md Date signed 4/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03777

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 94

1. PLACE OF DEATH

County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yeare.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thompson Ramsey Reed.

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Widower

6.(b) Name of husband or wife: Julia E Reed.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 7. 1866

8. AGE:	Years	Months	Days	If less than one day
	81	11	18.	hrs. ..... min.

9. Birthplace: North East Md.

(Town, county, and state)

10. Usual occupation: Retired Farmer.

11. Industry or business

FATHER 12. Name: William Reed

13. Birthplace: North East Md.

MOTHER 14. Maiden name: Margaret Furgeson.

15. Birthplace: North East Md.

16. Informant: Chester Reed.

Address: North East Rd Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 28-48 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Bay View Md

18. Funeral director: Joseph P Grant

Address: north East Md

19. 4-28 (Date rec'd by registrar) 1948 Lida V. Owens per M.B.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1948 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Disease.	
Due to: Arterio sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P. L. Dodson M.D. Medical Examiner for Cecil County M. D. or other

Address: Rising Sun Md. Date signed: 4-25-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 1a 03778

Reg. Diat. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Nottingham RD 1 Pa (Calvert md)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Calvert md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Jennie L. Reisler

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles M Reisler

6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): Sept 24 1860

8. AGE:

Years	Months	Days	If less than one day
87	6	22	hrs. min.

9. Birthplace: near Rising Sun, Cecil Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER

12. Name: Joseph Stephens

13. Birthplace: Penna

MOTHER

14. Maiden name: Philena Lee

15. Birthplace: Penna

16. Informant: John Reisler

Address: Nottingham R 1 Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-19-48 (month) (day) (year)

Cemetery or crematory: Rosebanks

Location: Calvert Md

18. Funeral director: Joseph R Grant

Address: north East Md

19. (Date rec'd by registrar) apr 17 19 48 (Registrar) L M Whiston

Remit-issued 4-17-48

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1948 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to April 15 1948

and that I last saw her alive on April 15 1948

Immediate cause of death: Nephritis

Arteriosclerosis

DURATION: 12 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F B Robinson M.D. M. D. or other

Address: Oxford Penna Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03779

131a

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton - Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Elkton Md R. D. 3

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Lewis Edward Roseberry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Sophie Roseberry

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 4 - 1894

8. AGE: Years	Months	Days	If less than one day
53	7	0	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Fibre Mill

FATHER 12. Name: Andrew J. Roseberry

FATHER 13. Birthplace: Pulaski Virginia

MOTHER 14. Maiden name: Agnes Cloer

MOTHER 15. Birthplace: No Record

16. Informant: Mrs Sophia H. Roseberry

Address: Elkton Md R. D. 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: apr 7 1948 (month) (day) (year)

Cemetery or crematory: Newark Del

Location: Newark Del

18. Funeral director: P. T. Jones

Address: Newark Delaware

19. April 7 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4th 1948, at 11.45 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 27 1948, to Apr. 4th 1948.

and that I last saw h.. alive on April 4th 1948.

Immediate cause of death	DURATION
Cardio - vascular - renal disease - hypertensive	Unknown
Due to: type.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. H. McKnight M.D. M. D. or other

Address: Elkton - Md Date signed 4/4/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03780

121

CERTIFICATE OF DEATH

Reg. Diat. No. 9r

1. PLACE OF DEATH:

County Cecil

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary J. Simcoe

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife J. Summerfield Simcoe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 3 - 1857

8. AGE: Years 91 | Months 3 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Jones

FATHER 13. Birthplace Delaware

MOTHER 14. Maiden name Mary Foxwell

MOTHER 15. Birthplace Delaware

16. Informant Miss Hilda Moffit

Address North East, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 14 1948 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location North East Maryland

18. Funeral director Joseph R. Arnett

Address North East, Maryland

19. April 13 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 1948 at 5:50 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1948, to 11 April 1948 and that I last saw h..r alive on 11 April 1948

Immediate cause of death	DURATION
Peritonitis	3 days
Due to Acute suppurative appendicitis	4 days
Due to	
Other conditions Arteriosclerotic Cardio-vascular disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Klaus H Haehner M.D. M. D. or other

Address North East, Md Date signed April 14 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159 037842

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Union Hosp.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: ~~Elkton~~ Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Boy Boy Stubbs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 28, 1948

8. AGE: Years 0 Months 0 Days 0 If less than one day 0 hrs. 35 min.

9. Birthplace Elkton Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Taylor Stubbs

13. Birthplace Md

MOTHER 14. Maiden name Wilda McCauley

15. Birthplace Md

16. Informant Hosp Records

Address Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-3-48 (month) (day) (year)

Cemetery or crematory Bethel May 3 1948

Location Chesapeake City Md RD

18. Funeral director H W Pippin

Address Elkton Md

19. May 3 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 19 48, at 2.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/28 19 48 to 4/28 19 48

and that I last saw h. alive on 4/28 19 48

Immediate cause of death	DURATION
Premature Foetus 6 mos	
Due to Cause Unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide [redacted] no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury none Injured at work?

23. SIGNATURE H. Y. Davis MD M. D. or other

Address Chesapeake City Md Date signed 5/1/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03782

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 11 mos. 14 days

Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.

How long in hospital or institution? 6 yrs. 6 mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Lansdowne P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: Spanish-American

3.(a) FULL NAME: TURNER, Charles T.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1874

8. AGE: Years	Months	Days	If less than one day
73	4	6	hrs. min.

8. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER
12. Name: Unknown - deceased
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown - deceased
15. Birthplace: Unknown

16. Informant: Hospital Records

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 4, 1948 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. May 4 19 48 Irene E. Dougherty
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29, 19 48 at 6:52 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 19 42, to Apr. 29, 19 48 and that I last saw him alive on April 29, 19 48

Immediate cause of death	DURATION
Pneumonia, bronchial, left	72 hrs.
Due to: Tuberculosis, pulmonary, bilateral, far advanced	Unknown
Due to:	
Other conditions: Arteriosclerosis, generalized, moderate	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work?

23. SIGNATURE: H. Nagler
H. NAGLER, M.D., Acting Chief Professional Services
MD or other

Address: VAH, Perry Point, Md. Date signed: 5-3-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03783

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs. 7 mos. 21 das.

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 Rose Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3. (a) FULL NAME: THOMAS TWILLEY

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Divorced

6.(b) Name of husband or wife: Mrs. Hattie Twilley

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): April 1, 1893

8. AGE:

Years	Months	Days	If less than one day
55	0	22	...hrs. ...min.

9. Birthplace: Salisbury, Maryland
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-26-48 (month) (day) (year)

Cemetery or crematory: Unknown

Location: Salisbury, Maryland

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland

19. April 26 19 48 (Date rec'd by registrar) Irma E. Dougherty (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23rd 19 48 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2, 19 37, to April 23 19 48 and that I last saw h... im ...alive on April 23rd 19 48

	DURATION
Immediate cause of death: Subdural hemorrhage, right	7 days
Due to: General paralysis, cerebral type	Unknown
Due to:	
Other conditions: Broncho-pneumonia, right	6 days

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: A. E. Trollinger A. E. TROLLINGER, M.D., Chief, Prof. Serv.

Address: VAH, Perry Point, Md. M. D. or other

Date signed: 4-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1241 CD

03784

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years 13 days

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Georgia County: DeKalb

City or town: Decatur
(If outside city or town limits, write RURAL and give nearest town)

Street No. 118 Champlain Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: Frederick L. Walker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Harriet S. Walker

6.(c) If alive, give age: —— years

7. Birth date of deceased (mo., day, yr.): July 27, 1893

8. AGE: Years	Months	Days	If less than one day
54	8	17	____ hrs. ____ min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Canteen Manager

11. Industry or business:

FATHER
12. Name: H. L. Walker
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-14-48 (month) (day) (year)

Cemetery or crematory: Unknown

Location: Atlanta (Decatur), Georgia

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. April 14 1948 Irene E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14th 1948, at 5:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1943, to April 14th 1948

and that I last saw him alive on April 14th 1948

Immediate cause of death	DURATION
Hemorrhage, massive, gastric	48 hours
Due to: Esophageal varices	Unknown
Due to: Cirrhosis of the liver	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of ____

Where did injury occur? —— (City or town) —— (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work? ——

23. SIGNATURE: A. E. Trollinger, M.D., Chf. Prof. Services
M. D. or other

Address: VAH, Perry Point, Md. Date signed 4-14-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH 131a 03785

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Rural Near Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
R.D.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Rural Near Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Singerly Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Elizabeth Walters

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Married.

6.(b) Name of husband or wife: William Walters

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 13, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	10	13		

9. Birthplace: Elkton Cecil Co Md
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Luke Goodyear
13. Birthplace: Elkton, Md

MOTHER
14. Maiden name: Margaret Woodside
15. Birthplace: Elkton, Md

16. Informant: William Walters
Address: Elkton Md Singerly Rd.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Apr 29 48 (month) (day) (year)

Cemetery or crematory: Cherry Hill

Location: Cherry Hill Md

18. Funeral director: H.W. Tippin

Address: Elkton, Md

19. April 28 1948 (Date rec'd by registrar) F.R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 April 1948 at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 April 1948 to 26 April 1948 and that I last saw h.er alive on 26 April 1948

Immediate cause of death	DURATION
Cardiac Failure	4 days
Due to: Senility	
Due to: Cardio Renal Disease	Unknown
Other conditions: Partial Obstruction	3 days
Possible Pulmonary T.B.C.	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George J. Kreis Jr. M.D. M.D. or other

Address: Elkton, Md. Date signed: 26 April 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of spelling of first name shown on:

FILM No. G 116 AUG 11 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

178c

03786

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? working on road

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Freeland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War 2 V

3. (a) FULL NAME: Marlin Mervin E Wilhelm

3. (b) Social Security Number: 216-07-5573

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9 1909

8. AGE:

Years	Months	Days	If less than one day
38	11	2	..... hrs. ..... min.

9. Birthplace: Baltomore Co. Md. (Town, county, and state)

10. Usual occupation: Handy Man

11. Industry or business

FATHER

12. Name: Phillip H. Wilhelm

13. Birthplace: Balto. Co. Md.

MOTHER

14. Maiden name: Mary G. Diffenderfer

15. Birthplace: Balto. Co. Md.

16. Informant: Phillip Russell Wilhelm

Address: 35 S. Fulton Ave. Bal to. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr. 13/48 (month) (day) (year)

Cemetery or crematory

Location: New Baltimore, Md

18. Funeral director: H.W. Hopkins

Address: Elkton, Md

19. April 13 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1948 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carbon Monoxide Poisoning.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: yes. CarB. Monoxide Poison

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 4-11-48

Where did injury occur? Elkton (City or town) Cecil (County) Md (State)

Injured at home, farm, industry, public place (where?) Cabin

Means of injury: gas heater Injured at work? no

23. SIGNATURE: P L Woodward M.D. Medical Examiner for Cecil Co.

M. D. or other

Address: Rising Sun, Md. Date signed: 4-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03787

Reg. Dist. No. 92

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, Institution, or street address where death occurred:
Union Hosp.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harold Williams

3.(b) Social Security Number: 236-05-2056

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Sadie Williams
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11 1904

8. AGE: Years	Months	Days	If less than one day
43			..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business

FATHER
12. Name: Bert Williams
13. Birthplace: W Va

MOTHER
14. Maiden name: Nellie Barnett
15. Birthplace: W Va

16. Informant: James E Thompson
Address: 4 Rolling Wood Manor Elkton Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr 12 1948 (month) (day) (year)
Cemetery or crematory
Location: East Bank W Va
18. Funeral director: H W Prigg
Address: Elkton Md

19. Apr 12 1948 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 April 1948, at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 April 1948 to 10 April 1948 and that I last saw h.. alive on 9 April 1948

	DURATION
Immediate cause of death: Uremia	2 days
Due to: Hypertensive Cardiovascular Renal Disease	3 years (?)
Due to:	
Other conditions: Terminal right lobar Pneumonia (Include pregnancy within 3 months of death)	24 hrs.

Major findings of operations
Date of op.
Autopsy results: Cerebral edema; rt. lobar pneumonia; chronic nephritis;
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Klaus H Huebner M.D.
M. D. or other
Address: North East, Md Date signed: 10 April 48